STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155233	A. BUILDING 01 B. WING	09/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/09/11 Facility Number: 000138 Provider Number: 155233 AIM Number: 100266500 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Batesville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and single station smoke detection in all resident sleeping rooms. The facility has	K0000	Preparation and/or execution of this Plan of Correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	a capacity of 86 and had a census of 83 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/14/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in the written plan for the protection of 83 of 83 residents in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all residents in the facility. Findings include:	K0048	It is the intent of this facility to insure a written plan is in place for the use of kitchen fire extinguisher for the protection of all residents. A. Corrective Action Taken: 1. The Fire and Disaster Manual was updated to include the use of the kitchen fire extinguisher (K Class) to address the use of Type K class fire extinguisher in relationship with the use of the kitchen overhead extinguisher system and a placard posted next to the extinguisher indicating its use is secondary to the hood extinguishing system. 2. All staff have been inserviced on the updates to the Fire and Disaster Manual. B. Others Identified: 1. There were no other residents having the potential to be affected. C. Measures Taken: 1. All staff were inserviced on new updates to the Fire and Disaster Manual 2. The Maintenance Supervisor/designee will monitor and insure posting of the placards	10/07/2011

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	Based on a review of the facility's written fire disaster plan labeled Disaster Plan for The Waters of Batesville on 09/09/11 at 8:45 a.m. with maintenance aide # 1, the fire disaster plan did not address the use of the ABC type fire extinguisher and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Furthermore, the ABC type fire extinguisher and the K class fire extinguisher lacked placards indicating their use is secondary to the overhead hood extinguishing system. Based on an interview with maintenance aide # 1 and the administrator on 09/09/11 at 10:20 a.m., the kitchen staff are not trained to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher. The lack of identification and use of the ABC type fire extinguisher and K class fire extinguisher in the Kindred Emergency Plan was confirmed by the administrator at the 12:30 p.m. exit conference on 09/09/11. 3.1-19(b)		in the kitchen area. D. How Monitored: 1. The Maintenance Supervisor/designee will conduct an monthly audit to insure placards are in place as a part of the Preventive Maintenance Program. 2. All new staff will receive a copy of the updated Fire and Disaster Manual. 3. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/7/2011.	

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K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to ensure 16 of 22 fire alarm boxes were located not less than 3 1/2 feet and not more than 4 1/2 feet above the floor. LSC 9.6.1.4 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 2-8.1 requires the operable part of each manual fire alarm box shall be not less than 3 1/2 feet and not more than 4 1/2 feet above the floor. This deficient practice could affect all residents in the facility. Findings include: Based on observation and measurement of fire alarm boxes on 09/09/11 during a tour of the facility from 8:30 a.m. to 12:30 p.m. with maintenance aide # 1, the following fire alarm boxes were mounted between four feet nine inches and five feet four inches above the floor: the one fire alarm box in ICF Hall, the one fire alarm box in the 77 back Hall, the one fire alarm box at the ICF Hall nurses' station, the one fire alarm box in the 39 front Hall, the four fire alarm boxes in the kitchen and main dining room, the one fire alarm box in the corridor by the dining room smoke barrier door, the one fire alarm box in the corridor by the assistant director of nursing office, the two fire alarm boxes in the ICF Hall by the smoke barrier doors, the one fire alarm box in the Rehabilitation Back Hall by the smoke barrier doors, the one fire alarm box in the Rehabilitation Hall by the north smoke barrier doors, the one fire alarm box in the front nurses' station, the one fire alarm box in the Administration Hall by the exit door. This was verified by maintenance aide # 1 at the time of observations and confirmed by the	K0052	It is the intent of this facility to insure all fire alarm boxes are located properly to meet set standards. A. Corrective Action Taken: 1. All 16 fire alarm boxes were repaired to meet set standards B. Others Identified: 1. Maintenance Supervisor/designee completed a 100% audit of all facility fire alarm boxes to insure they meet set standards. C. Measures Taken: 1. Maintenance Supervisor/designee will monitor all of the fire alarm boxes monthly as a part of the Preventive Maintenance Program for compliance. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/7/2011.	10/07/2011

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	administrator at the 12:30 p.m. exit conference on 09/09/11. 3.1-19(b)			
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to maintain 2 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 96, 7-2.1.1 which requires a placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area. Additionally, NFPA 10, 1998 Edition, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, it is preferential to activate the fixed system before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 09/09/11 at 10:40 a.m. with maintenance aide # 1, there were two portable fire extinguishers in the kitchen. One, an ABC type, was conspicuously placed on the west wall of the kitchen near the food storage room and the second extinguisher, a K class, was located on the east wall and both fire extinguishers lacked placards. Based on interview on 09/09/11 at 10:55 a.m. with maintenance aide # 1, it was acknowledged the ABC type and K class type portable fire extinguishers in the kitchen lacked placards identifying their use as secondary backup to the automatic fire suppression system located near the stove hood. This was verified by the	K0069	It is the intent of this facility to maintain the kitchen fire extinguisher in the kitchen cooking area to meet set standards. A. Corrective Action Taken: 1. A placard was posted next to the Type K portable fire extinguisher located in the kitchen cooking area. B. Others Identified: 1. No others areas were identified as affected. C. Measures Taken: 1. Maintenance Supervisor/designee will monitor the placement of the placard monthly as a part of the Preventive Maintenance Program to assure set standards are being met. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/7/2011.	10/07/2011

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	administrator at the 09/09/11, 12:30 p.m. exit conference. 3.1-19(b)			
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs was provided with at least a 45 minute fire rated door. This deficient practice could affect 12 residents on ICF Hall near the oxygen storage room. Findings include: Based on observation on 09/09/11 at 12:15 p.m. with maintenance aide # 1, the fire rating tag was illegible on the corridor door to the oxygen transfer room on ICF Hall near the nurses' station, which could validate it was at least a 45 minute rated door. Based on interview on 09/09/11 at 12:25 p.m. with maintenance aide # 1, it was acknowledged oxygen transfer occurs in the oxygen storage room on ICF Hall and the corridor door fire rating label on the oxygen storage room door was illegible. This was confirmed by the administrator at the 12:30 p.m. .exit conference on 09/09/11. 3.1-19(b)	K0143	It is the intent of this facility to insure the Oxygen Storage Room has a 45 minute fire-rated door. A. Action Taken: 1. The facility has replaced the Oxygen Storage Room door and has documentation showing fire ratings to meet set standards. B. Others Identified: 1. There is no other Oxygen Storage Room. C. Measures Taken: 1. Maintenance Supervisor/designee will conduct monthly audits to insure proper documentation is in place as a part of the monthly Preventive Maintenance program D. How Monitored:	10/07/2011

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			1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/7/2011.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with a functional alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an	K0144	It is the intent of this facility to insure that the emergency generator is provided with a functional alarm annunciator in a location readily observed by operating personnel. A. Action Taken: 1. The remote generator alarm annunciator was relocated to a readily-observed nurses station. B. Others Identified: 1. The facility only has one generator. C. Measures Taken: 1. The Maintenance Supervisor/designee will monitor proper operation of the remote alarm monthly as a part of the Preventive Maintenance Program. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation	10/07/2011

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	engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff. Findings include: Based on observation on 09/09/11 at 11:15 a.m. with maintenance aide # 1, the remote alarm annunciator for the generator was provided in the transfer switch room, located down the corridor from the ICF Hall nurses' station. Furthermore, the test switch on the remote alarm annunciator was tested and the audible alarm could not be heard at the ICF Hall nurses' station with the transfer		of compliance with all regulatory requirements, our date of completion is 10/7/2011.	

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	switch room door closed. Based on an interview with maintenance aide # 1 on 09/09/11 at 11:30 a.m., the remote alarm annunciator for the emergency generator could not be heard with the door closed and cannot be readily observed by staff during all shifts. 3.1-19(b)			
K0154 SS=F	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility's written fire watch policy failed to identify the person or persons assigned to each area of the facility during the fire watch in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period to protect 83 of 83 residents in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(c)2 requires an approved fire watch to be implemented in the event the automatic sprinkler system has to be	K0154	It is the intent of this facility to insure identification of the person or persons who will conduct the fire watch and whose sole responsibility it is to complete the fire watch. A. Action Taken: 1. The Fire and Disaster Manual has been updated to insure the Emergency Assignments are listed and the responsibilities to that role only. 2. All staff were inserviced on updates to the Fire and Disaster Manual. B. Others Identified: 1. The facility only has one Fire and Disaster Manual. C. Measures Taken: 1. Maintenance	10/07/2011

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	placed out of service for 4 hours or more in a 24 hour period. LSC 3.3.77 defines a fire watch as a person or persons assigned to an area for the purpose of protecting the occupants from fire or similar emergencies. This deficient practice could affect all residents in the facility. Findings include: Based on a review of the Fire Watch Policy on 09/09/11 at 8:45 a.m. with maintenance aide # 1, the Fire Watch Policy for the automatic sprinkler system lacked identification of the person or persons who would perform the fire watch in the event the automatic sprinkler system was out of service for four hours or more in a twenty four hour period. This was verified by the administrator at the 09/09/11 exit conference at 12:30 p.m. 3.1-19(b)		Supervisor/designee will review Emergency Assignments monthly at fire drills and yearly fire and disaster inservices. D. How Monitored: 1. CEO/designee will monitor monthly fire drills and yearly fire and disaster inservice results at quarterly QA & A meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/7/2011.	
K0155 SS=F	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility's written policy in the event the	K0155	It is the intent of this facility to insure a written policy to identify the person or persons assigned	10/07/2011

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	fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period failed to identify the person or persons assigned to each area of the facility during the fire watch to protect 83 of 83 residents in accordance with LSC, Section 9.6.1.8. LSC 3.3.77 defines a fire watch as a person or persons assigned to an area for the purpose of protecting the occupants from fire or similar emergencies. This deficient practice could affect all residents in the facility. Findings include: Based on a review of the Fire Watch Policy on 09/09/11 at 8:45 a.m. with maintenance aide # 1, the Fire Watch Policy for the fire alarm system stated a fire watch would be initiated during the period the fire alarm system was out of service for four hours or more in a twenty four hour period, however, the Fire Watch Policy lacked identification of the person or persons who would perform the fire watch in the event the fire alarm system was out of service for four hours or more in a twenty four hour period. This was verified by the administrator at the 09/09/11 exit conference at 12:30 p.m. 3.1-19(b)		to each area of the facility during a fire watch. A. Action Taken 1. The facility Fire and Disaster Manual was updated to show Emergency Assignments and their sole responsibility during the fire watch. B. Others Identified: 1. The facility has only one Fire and Disaster Manual. C. Measures Taken: 1. Maintenance Supervisor/designee will review Emergency Assignments monthly at fire drills and yearly fire and disaster inservices. D. How Monitored: 1. CEO/designee will monitor monthly fire drills and yearly fire and disaster Inservice results at quarterly QA & A meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/7/2011.	